सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

DAKSHATA

Guidance for

MENTORING AND SUPPORT VISIT

MSV 6

Designed and printed with support from
The Children's Investment Fund Foundation

CIFF CHILDREN'S INVESTMENT FUND FOUNDATION

OBJECTIVE

The objective of this visit is to facilitate the process of ensuring availability of all supplies, organization and disinfection of labor room (LR), onsite capacity building of health workers through emergency drills, record keeping and review through dashboard indicators with a follow-up for completion of activities as planned in the action plan of previous visit.

DELIVERABLES OF MSV 6

Time since completion of training	Availability of drugs and supplies	LR organization	Adherence to IP and cleanliness protocols	Data recording and reporting	Essential practices training
4 month	Ensuring availability of 61 items as per Dakshata Guidelines	Ensuring LR organization as per previous MSVs	LR disinfection	Dashboard indicators	Emergency drill on conducting normal delivery, AMTSL and newborn resuscitation

DESCRIPTION OF ACTIVITIES

Prepare

- Inform the facility/medical officer in-charge (MOI/c) at least one day in advance about the visit. Request time to have all relevant staff at one place for on-site drill.
- Carry all essential models and supplies for conducting the drill.
- Ensure complete MSV 6 package and previous action plan is available on the day of visit.
- Meet the facility in-charge after reaching the facility and then proceed to LR.

Observe

Visit the labor room (LR) and complete the MSV sheet:

1. Physically verify the availability of 61 items as per Dakshata guidelines. Note any missing supplies and the level of bottleneck.
2. Observe the completion of LR standardization as per the previous action plans.
3. Check for the LR disinfection protocol.

Facilitate

Meet with the MOI/c, LR in-charge, and central store keeper to facilitate the following:

1. By this visit, all drugs and supplies necessary as per Dakshata guidelines should have been made available at the facility. Discuss the issue at district or state level (as applicable), if the gap remains unresolved at facility level administration.
2. Discuss action plans with clear timelines and responsibility for supplies that can be ensured at the

facility level. For supplies that need support from district, prepare the plan with MOI/c.

3. By this visit, the labor room standardization should be complete. Help MOI/c prepare action plan and proposal for any infrastructural changes in the labor room to ensure standardization in line with the national guidelines.
4. Share the protocol for LR disinfection with the MOI/c and LR in-charge (Annexure I).
5. Review of dashboard indicators to track the progress and for necessary action planning based on identification of gaps. Help the facility team develop a mechanism for regular self-review of the dashboard of indicators and action planning for improvement.

Conduct Emergency Drill

The objective of an emergency drill is to:

- Assess and improve facility preparedness for managing basic and emergency obstetric situations,
- Objectively assess the translation of learned MNH skills in to practice in a non-threatening environment,
- Build capacity of health staff for early identification of warning signs and their timely and appropriate management,
- Streamline the communication and clinical decision making system in facility teams,
- Help facilities induct system level changes to create a quality enabling environment.

Conduct an emergency drill on conducting normal delivery, AMTSL and newborn resuscitation, as per Annexure II.

Action Plan Review

1. Review the action plan to see the status of activities since the last visit.
2. Discuss the observations from drill exercise on coordinated team effort to manage the emergency situation, and scope for improvement, as applicable.
3. Document this feedback at the facility level and plan for a reorientation on gaps identified in the essential skills of LR team, if needed.
4. Record new proposed activity with clear timelines and person-specific responsibilities.

Annexures

I.Protocol for labor room cleaning

Cleaning and disinfection of labor room	• The labor room along with all equipment and all surfaces should be cleaned every morning and all equipment and surfaces used should be cleaned after every delivery • Labor table should be cleaned in each shift and after each delivery with (a) cloth soaked in clean water (and soap water if required) (b) cloth soaked in chlorine solution • Cheatles forceps should not be kept in antiseptic, and should be autoclaved daily and kept in autoclaved bottle with the date and time labelled each day • Toilet should be cleaned with phenyl or lysol at start of each shift and after each delivery • The overhead tank supplying water to the labor room should be cleaned at least once a week
Daily at the beginning of the day	• The floor and sinks should be cleaned with detergent (soap water) or chlorine solution daily in the morning and thereafter every three hours. The floor should be kept dry • All the table tops and other surfaces such as lamp shades, almirah, lockers, trollies, etc. should be cleaned with low level disinfectant (2% carbolic acid) • Monitor machines should be cleaned with 70% alcohol
After each delivery	• Table tops should be cleaned thoroughly with chlorine solution or disinfectant (2% carbolic acid) • Disposable absorbent sheet placed on the labor table should be changed • Any spillage of blood or body fluids on the floor should be soaked with chlorine solution for 10 minutes. Should be absorbed in a newspaper and then mopped. The newspaper should be discarded in appropriate plastic bin
Procedure for mopping	• Prepare 3 buckets with clear water. Put phenyl or lysol or bleaching solution in one of the buckets. (So that you have two buckets of clean water and one bucket containing disinfectant) • The clean water buckets should be labelled as 1st, 2nd and 3rd bucket. The 3rd bucket will be containing disinfectant • The cleaning begins on the floor starting from inside to outside. Towards the end, all corners and groves have to be cleaned • After each sweep of the floor, the mop should be dipped first in the 1st bucket then in the 2nd bucket and lastly in the 3rd bucket containing disinfectant • Mops should be cleaned in the dirty utility area and put in the stand under the sun with the mop head upward and tilted, not straight • Mopping of floors should be done at least thrice a day and in-between

	whenever required • Mopping of floors should be done with water with detergent and disinfectant (phenolic based) in Negative Pressure Isolation rooms • In case of visible blood/body-fluids spills, the protocol of managing spills should be followed • All soiled mops should be treated as soiled linen and transported likewise in a covered (lid) container • At the end of each shift & a cleaning schedule for an area, all soiled mops should be sent through lift, in a hamper, to the laundry for washing • Mops should be visibly clean before starting cleaning of an area • Mops should be replaced after interim cleaning is done, as and when called for and mops kept in the wringer trolley should be well squeezed and out of the solution • Mops should be changed routinely and immediately following the cleaning of blood, body-fluids secretions and excretions, after cleaning contaminated areas, operation theatres or isolation rooms • Mops should not be left wet • Store mops dry in a designated well demarcated area away from the clean area • Mops should be washed in a laundry in a cycle dedicated for mops washing only with 1% Hypochlorite. This should be followed by a non-load disinfectant cycle with 1% Hypochlorite giving an exposure of 20 minutes at least • Personnel carrying out the cleaning and transporting the soiled mops should wear adequate PPE (gloves, mask, gown) • Trolleys transporting mops would be cleaned as per schedule with detergent followed by 1% hypochlorite / 70% isopropyl alcohol –as per compatibility according to manufacturer's instructions • Hand-mops mounted on wipers should be used for the bathroom mopping after putting on gloves

II. Exercise for Emergency Drill

Important things to consider before the simulation exercise (preparation):

- Simulation drill exercises can be done in two ways – with or without prior information to staff.
- The facility in-charge should be informed in advance regarding the visit and its purpose without giving them any information about the clinical situation which will be managed to avoid any type of bias.
- The availability of facility service delivery team should be insisted during the exercise. If in case, availability of one or more key facility team members could not be ascertained, then alternative arrangements like telephonic availability should be requested. If it is not possible to ascertain the availability of key staff then appointment for different timings should be sought.
- It is expected that the facility to be visited will have all the required logistics available by this time.

The procedure for conducting simulation drills in the facility should be followed under three heads as mentioned below:

1. Before the exercise
2. During the exercise
3. After the exercise

1.Before the exercise

A.Briefing of facility in-charge and the Facility Team (FT) on the simulation drill exercise

A meeting of all the staff engaged in childbirth related care should be arranged on pre-decided date and time. Availability of the facility in-charge should be insisted for this meeting. The FT should be first informed of the objectives of the meeting/exercise. It should be explained to the team that this exercise is not a critical evaluation of their facility's functioning, but an exercise for their own understanding of their preparedness status for managing a complication. It will also be helpful for them in identifying the key gaps and subsequently bridging them.

Subsequently the process of the simulation should be explained to the FT members. Any question from the FT members should be answered. The mentor should make sure that all the facility team members understand the procedure, and are ready to play their respective roles in the care provision. Essentially, every team member is supposed to play the role they normally play for the care of a pregnant woman and a newborn in the facility.

Ideally the facility processes and status of supplies should remain as is, in order to have an effective learning experience for the FT. This should be communicated to the team at the time of briefing. However, if any team insists on reorganizing the facility or making any changes in the protocols before the initiation of the exercise, they should be allowed to do so and same should be discussed later on.

If possible and resources permit, the permission for video recording the exercise should be sought from facility in-charge to enable the team to review the care provision process and identify key areas for improvement. The recording will also help in giving crisp feedback when the exercise is over.

B.Introduction of standardized client and the observer team

Standardized client and the observers should be introduced to the facility team. It should be emphasized to the FT that observer and instructor are not to be considered present for all practical purposes. The instructor will prompt the key findings for which they are assessing the client. For example, if they are assessing the client for BP, the instructor will prompt the recordings like 160/110.

1.During the exercise

The exercise starts with arrival of the client and her attendant in the facility, where the FT receives, assesses and manages the client as per their understanding and facility protocols. During this process, the observers should record their observations of facility performance and standardized client clinical outcomes on a standard observation recording sheet. During the simulation, the facility team should perform examinations, assessments, and maneuvers on the standardized client short of actual invasive procedures. For example, for recording FHR they should use a method - fetoscope, stethoscope, or fetal Doppler; for BP measurement they should tie the cuff of the BP apparatus on the arm of the standardized client; they should prepare syringe/vacutainers, stillette for pricking without actually pricking the standardized client. Since the standardized client uses a Mama Natalie/appropriate model during the exercise, the team members may also perform any vaginal procedure such as a PV. On performing such action, the observer should provide the result of the procedure or test to the team. For example, if the care provider completes the process of setting up the BP cuff around arm, the observer should prompt the BP value for the woman. Similarly, for any medication, the FT members should actually hand over any oral medicine to the standardized client. For any IM/IV drug, they should break the ampoules, fill up the syringe with appropriate doses, and act as if they are injecting the medicine, stopping short of actually injecting it. For starting an IV line also, the care provider should set up the IV set, and stop short of actually putting the IV line in the client.

The standardized client and her attendant may also try to create pressure situation and panic within the facility team to see the system level challenges.

The outcome of the simulation drill will be successful when the facility team appropriately manages the case and saves the life of mother and/or the baby, or unsuccessful when the team is unable to manage the client as per the recommendation even after reasonable time. Whatever the situation is, the mentor should conclude the drill exercise, and congratulate and thank the team for their participation. It needs to be ensured that all the relevant formats are being filled during the exercise for the purpose of documentation and giving feedback to the facility.

If possible, observer/mentor should record the whole procedure after taking due permission from facility in-charge to facilitate discussion later during debriefing meeting.

3.After the exercise

After completing the drill exercise, mentor should congratulate the team and organize a feedback meeting with the facility team. Following schema should be observed to give crisp and constructive feedback:

A.Debriefing

After the completion of the drill, mentor should sit with the staff to discuss on following points:

a) Good practices and congratulate
b) Main outcome of the task and completion of the task within time
c) Coordination or team work ability
d) Standard achievements

If time allows, drill video that was captured should be shown raising questions like:

a) What should have been done better?
b) What was not done right?

Mentor should never forget to correct the mistakes and discuss the main outcome of the exercise.

B.Re-run exercise (if required and time permits)

It is recommended that, the facility team should be allowed to complete one practice drill on the same case scenario, and is hoped that this time they will perform better. However, the observers/mentor should handhold and support the team members in successfully performing essential practices to prevent or manage complications. The same methodology should be used by the care givers for simulating tests, procedures, and medication as that for the assessment simulation.

CASE SCENARIO: NORMAL LABOR AND DELIVERY WITH ASPHYXIATED BABY

Geeta 21 year old G2P1 presents at full term in labor with the onset of contractions approximately 6 hour ago. She is a booked case with history of regular ANC check-ups. Her records indicate she is carrying a singleton pregnancy in the vertex presentation. Her past medical history is uncomplicated, she has no allergies, and she takes no medications other than supplements. Her prenatal labs tests are within normal limits and her pregnancy has been uncomplicated.

Observation	Yes	No	Prompts for the observer/standardized client	Instruction for standardized client	Remarks
Provider elicits relevant obstetric, medical and surgical history and reviews relevant medical records					
History of presenting complaints elicited and recorded				Pain in abdomen	
Relevant menstrual history elicited and recorded				9 months back	
Relevant obstetric history elicited and recorded				G2P1, rest of the obstetric history - nothing significant	
Relevant medical history elicited and recorded				Not significant	
Relevant surgical history elicited and recorded				Not significant	
Provider reviews investigation records			Hb, urine and others – within normal limits, HIV –ve, single fetus, vertex presentation, no cephalo pelvic disproportion	9 months back	
Provider conducts general physical examination/systemic examination					
BP recorded			110/70		
Temperature recorded			98°F		
Pulse			84/min		
Pallor, edema			Absent		
RS, CVS, CNS examination done			No significant findings		

Provider conducts per abdominal examination					
Providers palpates abdomen			Full term, cephalic presentation, contractions – 4 contractions per10 minutes, each lasting more than 40 sec		
Provider auscultates to elicit fetal heart rate			FHR – 140/min		
Provider conducts per vaginal examination					
Provider washes hands before doing PV examination using correct technique					
Provider wears gloves in both hands					
Provider follows proper technique of conducting PV Examination			Cervical dilatation – 5 cms, 80% effaced, Head at 0 station, membranes present		
Partograph plotting started			Rate of cervical dilatation is satisfactory, no fetal distress and all the maternal parameters are normal		
Preparation for conducting the delivery					
PPE available and provider wears them correctly (except gloves at this stage)					
Provider washes hands before doing PV examination using correct technique					

Provider wears sterile gloves using proper technique					
Provider switches on the radiant warmer/heat source at least half an hour prior to delivery					
Provider prepares delivery tray and bay tray					
Provider prepares newborn care corner with all essential equipment and supplies					
Provider loads uterotonic prior to conducting the delivery					
Was the client shifted to LR at appropriate time					
Provider conducts the delivery as per the facility specific protocols					
Provider placed two pre-warmed towels on mother's abdomen				Slowly start pushing the baby out	
Provider cleans perineum using proper technique (Apply nothing on model)					
Episiotomy done*					
Provider provides perineal support				Keep pushing the baby out	
Head flexion done				Push the head of the baby out	
Suction of baby after delivery of head done*					
Assisted the delivery of shoulders and body				Push the baby out completely	
Baby received on the mother's abdomen			Baby is not crying		

Provider performs NEW BORN RESUSCITATION (NBR)-Assesses breathing at every step, should be completed in 1 min consisting of 30 sec bag and mask ventilation, observer should take note of timings					
Provider looks for meconium					
Provider performs immediate suctioning of baby mouth followed by nose			Baby is NOT crying		
Provider thoroughly dries the baby using the first towel on mothers abdomen			Baby is NOT crying		
Provider immediately clamps and cuts the cord					
Baby shifted to designated NBC area immediately					
Positioning of baby with the use of shoulder roll done			Baby is NOT crying		
Suctioning of baby (mouth followed by nose) performed			Baby is NOT crying		
Stimulation in the form of rubbing the back or flickering of sole done by the provider			Baby is NOT crying		
Repositioning the baby and preparing for bag and mask ventilation done			Baby is NOT crying		
Bag and mask ventilation for thirty seconds with correct method and chest rising performed			Baby cried		
Observational care (cap, ID band, ensure warmth and early initiation of breastfeeding/assisted feeding) given			Conclude		

Check for labor room organization at the facility					
Baby warmer/heat source available					
Provider immediately clamps and cuts the cord					
Baby shifted to designated NBC area immediately					
Baby shifted to designated NBC area immediately					
Baby warmer/heat source available					
Baby shifted to designated NBC area immediately					
Baby warmer/heat source available					
For mother • Delivery tray prepared along with followings • 2 perineal pads • 2 artery clamps • 1 bowl with gauze pieces for antiseptic cleaning • Sponge holder • Scissors for cord cutting • Episiotomy tray prepared • Uterotonic (to be used immediately after delivery)					
Receiver for placenta available					
For essential newborn care – check for availability of • Two pre-warmed clean towels • Cord ligature/clamp • Mucus extractor • Cap for baby • Identification band					

For NBR at NBC area – check for availability of • Radiant warmer/heat source • Shoulder roll • Mucous extractor • Bag and mask (Size 0, 1) • Oxygen supply • Stethoscope • Working clock with second's hand					